



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GP LLP
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-13-0021-01

MFDR Date Received

September 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was processed and under paid. Starting in 2012, Code 29826 is now an add on code and is no longer endoscopic. The amount should not have an additional reductions [sic] other than the initial automatic write off (not even multiple procedure reductions). The 2012 Texas work comp fee schedule is \$359.89 and we expect payment in full. We are respectfully requesting you reprocess this claim and pay the additional amount due of \$179.94. "

Amount in Dispute: \$179.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 19 on September 12, 2012, assigned to Flahive Ogden & Latson. The DWC060 was stamped received by FOL Fileroom, Gordon Clayton on September 13, 2012. A decision will therefore be issued based on the information available for review at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2012	29826	\$179.94	\$179.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

1. Did the insurance carrier reimburse the requestor in accordance with the provisions of §134.203?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203,"(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."
 - The requestor disputes payment amount issued by the insurance carrier for CPT code 29826 for date of service May 25, 2012.
 - Medicare documents a multiple procedure indicator of 0 (Criteria does not apply) for CPT code 29826. Therefore, CPT code 29826 is not subject to the multiple procedure reduction. As a result, the requestor is entitled to additional reimbursement in the amount of \$179.93.
2. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of \$179.93.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$179.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$179.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 31, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.